From: Health Care for All/NJ
Sent: Saturday, July 15, 2006 10:59 AM
To: CHCWG Staff
Subject: CHCWG's Interim Recommendations

Attachments: CHCWG Interim Rec Comments.doc

Ladies & Gentlemen --

We recently sent the attached comments to each of the members of the Citizens' Health Care Working Group via US Mail. We did so because the on-line form provided on the CHCWG's web site didn't lend itself to expressing the points in our critique.

One of the Working Group's members subsequently sent us the CHCWH's staff members' e-mail addresses and suggested to us that we should also send our comments to you. They are attached hereto as a Word for Windows file.

Health Care for All/NJ commends you for the fine job you have done in collecting and tabulating the opinions of thousands of Americans, as documented in the material that accompanies the CHCWG's Interim Recommendations. We also want to go on record as agreeing with the Principles for health care that the CHCWG has enunciated.

But regardless of all the beautiful sentiments expressed in those principles, we believe that the primary function of the CHCWG, and the only one that will have any impact on the Executive and Legislative branches of government, will be the Recommendations that are required to be sent to the White House and the Capitol according to law.

As you will see from the attached comments, we believe that the Interim Recommendations don't follow the law's directive to reflect the opinions expressed by your survey's respondents that you so painstakingly documented and tabulated.

It is our hope that the Final Recommendations will be revised so as to correct that flaw.

Respectfully,
John Glasel, secretary
Health Care for All/NJ

Comments on Interim (6/1/06) Recommendations of the Citizens' Health Care Working Group

Thanks to the members and staff of the Citizens' Health Care Working Group for your diligent and thorough compilation of the hopes and desires of thousands of Americans from coast to coast. And thanks, too, to the members of the United States Congress who in their wisdom commissioned this exhaustive survey of their constituents. As long-time advocates for reforming our nation's health care system, this is the first time we can recall anyone other than professional pollsters surveying public opinion on the subject.

We fear, however, that these Interim Recommendations do not fully satisfy their mandate — to tell Congress what the people want. This can be partly attributed to some of the questions mandated by the legislation.

The Congressionally-Mandated Questions

The very first mandated question, "What health care benefits and services should be provided?" caused several difficulties. It implied that less than comprehensive benefits might be acceptable, and it raised the corollary question: who is to decide what benefits will be available?

The second and third congressional questions, "How does the American public want health care delivered?" and "How should health care coverage be financed?" were more open-ended, less controversial and yielded some valuable insights into public opinion.

But Congress' fourth question, about what "trade-offs" would be acceptable, gives credence to the suggestion that some "inside-the-Beltway" people may have lost touch with the American public (more on this later).

Interim Recommendation 1

Congress' first question led the Working Group to pose many questions in terms of "core benefits" or "a defined level of services." The CHCWG neatly finessed the difficulty that many participants had with that formulation[1] by asking whether they would want such "core" benefits to apply to everyone or merely to certain groups. Naturally, most respondents chose the more egalitarian option, so in addition to reflecting that choice, the CHCWG's first Interim Recommendation advocates "core health care services," a concept that derived only from the question, not the responses.

Interim Recommendation 2

The second Interim Recommendation artfully deals with the corollary question of who decides what benefits and services will be provided. In Appendices B and C, we learn that both on-line respondents and Community Meeting attendees preferred that consumers and medical professionals should make such decisions (with employers and insurance companies dead last at 0.8% and 0.5%,[2] or at 3.0 and 2.1 on a scale of 1 to 10,[3] respectively). But search as we may, we could find no question asking whether the benefits should be determined by "an independent, non-partisan public-private group." It's interesting that the Working Group didn't suggest that it might be not-for-profit! This recommendation seems to have emanated elsewhere than from survey participants.

Interim Recommendation 3

The third Interim Recommendation is that the new system should "guarantee financial protection against very high health care costs." But more than one-third of the survey's subjects — 34.1% of on-line respondents[4] and 33.9% of Community Meeting attendees[5] —thought that the system should pay for everyday health costs.

Everyone can agree with this Interim Recommendation's statement that "[n]o one in America should be impoverished by health care costs," although ensuring "[f]inancial protection for low income individuals and families" was low among Community Meeting attendees' priorities.[6] While not discussed by survey participants, such protection would require means-testing, which would entail considerable cost.

It is therefore surprising to see this Recommendation ignore both substantial minority opposition and the likelihood of higher costs by proposing "a national program (private or public)" that would probably resemble the high-deductible insurance scheme currently embodied in Medical Savings Accounts.

The "Dialogue with the American People" didn't indicate that it had asked Community Meeting attendees about high-deductible insurance coverage. But a considerable number of on-line respondents seem to have opposed this concept.[7] The third Interim Recommendation thus doesn't seem to reflect the opinions of the survey's participants.

Interim Recommendation 4

On the other hand, the fourth Interim Recommendation, to support integrated community health networks, was endorsed by respondents to the CHCWG's Internet Poll and the University Town Hall Meeting[8] [9] as well as Community Meeting attendees,[10] even though your question didn't specifically ask about "integrated *public/private* networks." (Emphasis ours)

Interim Recommendation 5

The fifth Interim Recommendation proposes that the Federal government use "the resources of its public programs for advancing the development and implementation of strategies to improve quality and efficiency . . . ." Little support for this idea was expressed by attendees of the Community Meetings,[11] although most on-line respondents agreed or strongly agreed that health care providers should upgrade their computerized information systems.[12] Absent any discussion of the subject by survey participants, the fifth Interim Recommendation lets the "private" component of "public-private" off the hook! Where spending money might be necessary, the CHCWG seems to favor "corporate welfare."

Interim Recommendation 6

It is likely that most Americans agree with the Working Group's on-line respondents[13] (Community Meeting reports were anecdotal[14]) in wanting to restructure end-of-life health care, as the sixth Interim Recommendation proposes. However, no questions on this topic asked participants whether this should be accomplished through "public and private" payers or programs, as the Working Group recommends.

Support for Single System

The CHCWG's survey found overwhelming support for a single-payer, universal, government health insurance program.[15] [16] [17] [18] [19] This finding shouldn't surprise members of the Working Group, its staff, or the politicians by and for whom this effort has been commissioned, since independent polling[20] has long reported that as many as three-fourths of Americans favor such a system, even if it would require higher taxes.

Yet the phrasing of many of the CHCWG's questions seemed intended to lead to different conclusions.[21] [22] Recognizing this, many participants qualified their responses.[23] In particular, the fourth congressionally-mandated question, asking what "trade-offs in either benefits or financing" were acceptable, proved to be difficult for many.

"No Trade-Offs!"

As the CHCWG succinctly reported, "The single most common response to the question about trade-offs can be summarized as 'No trade-offs.'"[24] Although not expressly tabulated, it reported that "Individuals [at Community Meetings] voiced support for a fairly comprehensive benefit system"[25] and "were not comfortable with bare-bones benefit packages."[26]

The tabulation of Internet poll responses to "trade-off" questions presents a more nuanced insight. Combining the "agree and "strongly agree" responses, 65.4% favored "paying more in taxes to have basic health insurance for all"[27] with 60.5% approving "limiting coverage for certain end-of-life care services of questionable value in order to provide more at-home and comfort care for the dying.[28] Significantly, 62.1% of on-line respondents disagreed or strongly disagreed with the idea of "expanding federal programs to cover more people, but *provide fewer services to persons currently covered by those programs."*[29] (Emphasis ours)

We believe that the relatively high number of "neutral" and "NA/NR" answers to these on-line questions indicated a high level of discomfort with the concept. This seems to show a disconnect between the well-insured elected officials who suggested "trade-offs" and those who will receive and/or provide health care under whatever system this effort may help to shape. We are reminded of a recent reaction to Congress' failure to increase the minimum wage: "[Set] representative's salaries at the minimum wage. If it's good enough for the rest of the country, it's good enough for Congress.[30]

Meetings' Preferences Should Be Reflected

To fairly report public sentiment to the President and Congress, you must acknowledge "the elephant in the living room," participants' support for a single-payer system, discussed above.[31] Whether or not the Working Group's members favor this idea, its Interim Recommendations should reflect this finding.

In its charge to the CHCWG, Congress ordered preparation of "an interim set of recommendations on health care coverage and ways to improve and strengthen the health care system *based on the information and preferences expressed at the community meetings."*[32] (Emphasis ours) Since support among Community Meeting attendees for a

single system was so overwhelming, it would be appropriate to list it first among the Interim Recommendations.

Tweak the Recommendations

It would be advisable to "tweak" the Interim Recommendations to satisfy Congress' directive that they reflect public sentiment as revealed at the Community Meetings. We suggest the following (using the existing numbers, even though we hope that a new first recommendation will be inserted):

Interim Recommendation 1: Delete "a set of core" before "health services," in the first explanatory paragraph.

Interim Recommendation 2: Delete "core" from title; delete "public-private" from first explanatory paragraph.

Interim Recommendation 3: Delete altogether, since participants' support was ambiguous, at best.

Interim Recommendation 4: Delete "public/private from first paragraph, and "public-private" from second bulleted point.

Interim Recommendation 5: If possible, urge that private providers should also be engaged in upgrading quality and efficiency.

Interim Recommendation 6: Delete "Public and Private" from the first two bulleted points.

We hope that the foregoing suggestions will be helpful to you in furthering the progress of this important project. Again, thank you for your fine work.

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[1] *Dialogue with the American People,* p.8: "[S]ome participants indicated that it was hard to make a choice between the answers without knowing *who* was providing the coverage, or what would be covered."

[2] *Appendix B,* p. 3, weighted average of responses from five Community Meetings where question was "Who ought to decide what is in a basic benefits package? (SELECT ONE)"

[3] Appendix B, p. 3: average of responses from 15 Community Meetings where question was "On a scale of 1 (no input) to 10 (exclusive input), how much input should each of the following have in deciding what is in a basic benefit package?"

[4] *Appendix C,* p. 1, question #2.

[5] *Appendix B,* p. 2, column 2

[6] *Appendix B,* p. 7: In answering the question "If you believe it is important to ensure access to affordable, high quality health care coverage for all Americans, which is most important to you?" meeting participants ranked the option to "Expand State Medicaid, SCHIP, etc." (all low-income programs) quite low.

[7] *Appendix C,* p. 5: 43.5% of on-line respondents disagreed or strongly disagreed with option #11 b, "Paying a higher deductible in your insurance for more choice in doctors and hospitals." (More than 20% declined to express an opinion on this subject.)

[8] *Dialogue with the American People,* p. 41: ". . . consistently ranked in the top four choices at the community meeting locations and in the Internet poll."

[9] *Dialogue with the American People,* p. 42, Figure 9: The largest number of participants agreed or strongly agreed with the option, "Expand neighborhood health clinics"; see also *Appendix C,* p. 9, option #12 f.

[10] *Appendix B,* p. 7: "Expand Neighborhood Health Clinics" was ranked 2nd or 3rd among proposals to ensure health care access at the 19 meetings where the question was asked in this way.

[11] *Appendix B,* p. 6: "Develop Health Information Technology" ranked last or very low priority among options suggested to Community Meeting attendees.

[12] *Appendix C,* p. 4: 37.5% agreed and 34.5% strongly agreed with option #9 i., "Doctors, Hospitals and other health care providers should invest more in computerized information systems to monitor and improve health care quality, reduce errors, and improve administrative efficiencies."

[13] *Appendix C,* p. 5: 60.5% of on-line respondents agreed or strongly agreed with option #11 e, "Limiting coverage for certain end-of-life care services of questionable value in order to provide more at-home and comfort care for the dying."

[14] *Dialogue with the American People,* p. 32: "Support also existed for limiting expensive yet 'futile' end-of-life care and instead providing palliative care."

[15] *Appendix B,* p. 7, column 8: at 25 of 29 Community Meetings "Create a National Health Program" was the most heavily favored answer to the question, "If you believe it is important to ensure access to affordable, high quality health care coverage and services for all Americans which [is most important to you/of these proposals would you suggest for doing this]?"

[16] *Appendix C,* p. 6: 72.2% of on-line respondents either "agreed" or "strongly agreed" with option #12 g, "Create a national health plan, financed by taxpayers, in which all Americans would get their health insurance." Conversely, the highest number of on-line respondents, 61%, either "disagreed" or "strongly disagreed" with option #12 c, "Rely on free-market competition among doctors, hospitals, other health care providers and insurance companies, rather than having government define benefits and set prices."

[17] *Dialogue with the American People,* pp. 4 and 41: "When asked to evaluate different proposals for ensuring access to affordable high quality health care coverage for all Americans, individuals at all but four meetings ranked *'Create a national health insurance program, financed by taxpayers, in which all Americans would get their insurance'* the highest."

[18] *Dialogue with the American People,* p. 42: 78% of respondents at the University Town Hall Meeting agreed or strongly agreed with the single payer option (as formulated in option #12g — see note 16, above).

[19] *Dialogue with the American People,* p. 30: "A commonly expressed view was that a simpler system would result in lower administrative costs. Participants believed that a more straightforward health care system would reduce administrative costs by eliminating duplication of services. At a number of meetings across the country, many individuals advocated a single payer system to eliminate the middleman, possibly one structured like Medicare or similar to the public school system. Under this type of system, everyone would pay taxes to support the system, even though, as with education, they might not use the services. Participants advocating the single payer concept said it would be the most efficient way to organize health care."

[20] *Dialogue with the American People,* p. 38: Four national surveys conducted from 2003 to 2005 found that many (up to 75% of) Americans would support guaranteeing coverage to all, even if it meant raising taxes.

[21] *Dialogue with the American People,* p. 22: "Others objected to the way the question was worded since they said it assumed implicitly that a national health care system would not exist."

[22] *Dialogue with the American People,* p. 23: "As with the previous question, some meeting participants expressed frustration with the way the question was worded and refused to answer. These individuals told the Working Group that they felt the questions implied continuation of the current delivery system. If a universal, possible single-payer system were implemented, their argument went, these questions would be irrelevant."

[23] *Dialogue with the American People,* p. 26: "Meeting participants who supported comprehensive reform through some type of national plan told the Working Group that, *in the absence of a national plan,* employers would need to be responsible, with tax breaks provided to assist small business." (Emphasis ours) — remember that these participants were part of an overwhelming majority favoring a single-payer system, as cited in notes 15, 16, 17, 18, & 19)

[24] *Dialogue with the American People,* pp. 10, 34.

[25] *Dialogue with the American People,* p. 10.

[26] Idem.

[27] *Appendix C,* p. 5, option #11 c.

[28] *Ibid.* option #11 e.

[29] *Ibid.* option #11 d.

[30] Henry Woronicz, letter to *The New York Times,* June 24, 2006, p. A14.

[31] See notes 15, 16, 17, 18, & 19, above, and referencing text.

[32] *Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173):* Sec. 1014 (h) (4) (D).